Regional Group of LDC East & West Sussex, East & West Kent and Surrey

Monday 16th January 2017

Attendees:

Barry Westwood (Surrey)
Toby Hancock (West Sussex)
Tim Hogan (Kent)
Annie Godden (NHS England)
Agi Tarnowski (LPN)
Nish Suchak (East Sussex),
Connie Sheridan (Kent orthodontist)
Emmanuel Lazanakis (West Sussex)
Snehal Dattani (Surrey)
Julian Unter (Kent)
Jackie Sowerbutts(PHE)
Richard Wilcynski (GDPC)
Robert Seath (East Sussex)

Apologies:
Nil

Minutes of Previous Meeting: Agreed as accurate representation of meeting

East Sussex

- Nish and his team are running a core training day on Friday 19th may 2017; details of which are to follow
- With the local oral health promotion for children, the local dentists are not engaging with assisting with getting staff out into the community
- East Sussex LDC has decided not to support Katy Jackson – Head of prescribing controlled drugs (East Sussex CCG) requesting that patients should not ask their GPs for Duraphat prescription, it should only come to dentists. And also to inform GPs not to prescribe Duraphat to patients in care homes. The LDC had decided that Brett's contact details be sent to the CCG for further information

Surrey

- Barry and Snehal feel that the Rego installation has had simplified training to go with the implementation of it in Surrey. They have been advised that Google Chrome is the preferred system although Rego will work with other systems such as Safari.
- Annie stated that additional training would be available in a one to one form from Vantage upon request. Also there will be some Vantage focus groups with the clinicians who wrote the referral pathways.

West Sussex

- Toby is still awaiting attendance of Stephen or Lawrence from Health Education KSS to a meeting to discuss their plans to spend the funds that we hold for them
- Toby has been developing ties with the LMC of West Sussex. He has attended a LMC meeting in Billingshurst, giving them an update on our status and 3 GP are attending our February meeting in West Chiltington.
- Toby and Mark have attended a one to one meeting with David Ezra to discuss the progress and development of Rego. There are plans to expand the system into electronic prescribing and laboratory referrals. Also there is the possibility of developing private referral bases, outside of their NHS contract.
- Agi's core training day was felt to be another success. East Sussex and Surrey are looking to undertake a similar format in coming weeks/months.

Kent

- Christmas breach notices were zero this year, mainly due to the hard work of the dental team ringing practices.
- Orthodontic Rego referral difficulties were noted, mainly through a lack of understanding and practice of using it.
- Barry requested if there could be a lack of penalty for failing to achieve targets for UOAs since the introduction of Rego. Annie responded that it would need to go to DCQAP for a case by case negotiation.
- Some Whistleblowing cases as grudge/blackmailing of previous owners have been experienced. Often directly to the GDC. There is a suggestion for dentists to lodge a "vested interested" status between themselves and the whistlebower. There is a request to raise the awareness of this within the LDCs.
- Tim highlighted the poor health of Shab and the whole committee wished him a speedy recovery.
- Tim is giving a talk in central London on Wednesday 15th March to Dental Core Trainees and Clinical Fellows covering LDC awareness.

Current contract matters and LPN

- Community and Unscheduled dental care contracts have been extended to April 2019.
- Agi has written a special care MCN questionnaire which she will forward to Channel members to get a feel for feedback of the service.
- Jenny Oliver has been recruited as a full time dental public health consultant for KSS

Orthodontic needs assessment and contract tendering parameters

Jackie was previously sent these questions (responses in red):

1. Five-year time limited contracts are an impossible business model for anybody who is not already a PDS or GDS provider or does not have considerable financial backing. No lender or landlord would countenance an agreement over this period. This may be seen at appeal as a restriction of patient choice and an unfair advantage to existing Providers and Corporate Groups. What is your response to this perceived restriction of opportunity and choice? Can't answer specifically but would look to have longer than 5 years, awaiting "central" response with the hope for substantially longer contract times

2. You speak of a pan-area UOA value of £56.50. In your report you say that the average UOA value across the area is £63 although a median value would be more accurate. A median value of £60.76 was disclosed under FOI for Hampshire in 2011, so given rises since then £63 seems to be about the median for the South and South East of England but you have arrived at a value of £56.50. Do you have any business model to support this or is it a figure plucked out of the air? If you have chosen this figure after engagement with Orthodontic Providers based in the South East with attendant high employment and high expenses, could you explain how they have helped you to arrive at this figure? Again, this is perceived to be beneficial to Providers able to withstand initial financial loss to eliminate Patient choice. Please explain how this is not so and who has helped with the model. UOA value came from the transitional document, suggestion that value could have been as low as £48.39. Orthodontists are encouraged to undertake their own business model assessment and bid what their business requires rather than aim for an "ideal procurement target"

3. The approximately 50% reduction in non-productive assessments/reviews shown in your report translates to about £31 per treatment in Surrey and £40 in Kent/Medway. This is a sharp reduction in profits already and means an Orthodontist is already providing many more treatments per contract than at the assessment period prior to 2006. How have you factored this possible extra

strain on performance into the figure of £56.50 which in effect becomes far less as the average of £63 is prior to the assessment reduction? How would you be able to demonstrate in this scenario that price is not the consideration to the detriment of the quality of provision and choice and that the tariff is consistent with national net averages, transparent and in the best interests of patients? Is this tender process only happening in the South East of England - what about the rest of the country? What consideration has been given to the varying costs on delivering treatment and sustaining service provision in each location? The LAT had pointed out very plainly to Orthodontic providers that it was in their best interests to achieve parity between referrals and treatments and therefore the reduction figures are not a true picture as Providers felt pressurised into the legally grey area of providing free private assessments – this is the BDA position on which they have taken advice. The DERS system appears to be working well, but have the Commissioners considered the possibility of legal challenges by patients in the future against the on-line system? It was generally agreed that the driver for the reduction in Orthodontic referrals had been misunderstood by Jackie and Annie. The reality is that many Providers have not claimed for non-qualifying referrals following pressure from the team at Lewes to achieve parity and most, if not all of the group had heard reports of this "initiative". Connie, orthodontist from Kent also corroborated this.

4. Transfer cases. As you are reducing the number of contracts it makes little sense to say that it would be a matter of swings and roundabouts to pay nothing for these cases. There would be more swings to drop patients off than roundabouts to pick them up. This would mean that Orthodontists will have a fair amount of unpaid work imposed on them along with the proposed UOA value reduction and this unpaid work may even lead to contract underperformance and breach notices. How can this not be to the detriment of provision? The question of dealing with transfer cases from unsuccessful providers needs to be quantified accurately. What is the proposed model? British orthodontic society and British dental association have been in discussions with NHS England. Earlier proposals for a complex differentiated payment has been replaced with an offer of £662 as a one off payment per patient to complete the treatment. There is a general sense that BDA would accept this as long as BOS were supportive

5. Distances between practices and increased working hours. Travelling times across the LAT vary enormously. It may take less time to travel 20 miles in one area than it does 4 in another but this doesn't seem to have been considered. Can you demonstrate if and how these variations have been recognised? Most children take a session (i.e. morning or afternoon) off school for Orthodontic appointments, usually for only 10-12 visits, so extended hours are an unnecessary burden on potential Providers. There are many infrastructure issues such as staff looking after their own children, retention of staff, hours of cleaners etc. so that any anticipated service enhancement needs to be proven. The hours of 7.30 to 9.30 am and 4.30 to 6.30 pm are the times that our roads are most congested as you will know. Government statistics show that Surrey has the slowest roads in the country at these times and I am sure it's not much better over the whole area. Could you therefore explain how this disruption to working lives would benefit anyone?

6. Standardised waiting lists. It is impossible to standardise waiting lists as GDS Providers will always prefer to refer to those practices which they perceive to provide the best outcomes for their patients. I remember having this conversation with you at East Surrey PCT about 15 years ago, so has someone found a way to standardise waiting times whilst protecting patient choice? The new DERS system is surely able to record the waiting lists and times of initial visit to treatment. Is this so?

7. The model you show of two-centre contracts with one Provider is heavily-biased in favour of Corporate bodies given the short period of time available for other Providers to get together and align their working practises, IT systems, staffing arrangements etc. and to produce potentially successful tender documents for their services. Could you explain how this isn't the case? Also if the same Provider is in two adjacent areas that is a massive restriction on patient choice since if a patient is unhappy with one branch they could only transfer to the other and could possibly see the same clinician. You couldn't reasonably expect them to transfer to another Orthodontist who would receive zero payment and if the patient was dissatisfied with the pairing they would actually have much further to travel than they do at present. Has this been considered? The non-colour format of your document makes it impossible for us to make sense of the demographic figures provided, but there are areas such as Maidstone and Eastbourne with only one contract each and potential increases of 7% in 12 year olds where there is possible reduction in provision and definite intended reduction in patient choice. How is this justifiable? It is felt that management of sub 1000 UOA contracts is too onerous but it is not the only reason for encouraging larger contract sizes. However 15,000 is not set in stone and practices should consider what contract size would fit their business plan.

8. Your UOA figure is generally seen as unworkable except to the detriment of quality, and this by owner-Providers with personal input to fee income. Corporate bodies have no management input to income but a management tier to pay for and investors who require dividends and positive returns on capital. The inherent questions are obvious, so could you please explain how this is a level playing field for all potential bidders?

Jackie will be summarising our points along with other stakeholder groups feedback.

AOB

- LDN: Julian discussed the Kent position for a generalised Option 1 style however the core was not to be the decision maker, only the idea generator, decisions would be taken to the wide LDN for agreement and implementation. However a vote was taken for the Channel wide response to Gemma/Brett. Tim and Julian abstained from the Vote and 8 voted for an option 2.
  Barry responded to Gemma via email on Wednesday 18th January: "*We had a wide and lengthy discussion regarding the LDN options at Monday's meeting and after a vote the majority decision was reached to follow option two - one large LDN across KSS with representation from each area.*
  We're very aware of the possible problems associated with large groups and the logistical difficulties but it was felt that option two would encourage transparency and cooperation. Given that it is untried and that there is no clear perfect solution we would like to trial this arrangement for a year and then see how it is working.
  We suggest that decision-making be left to the LDN and not small core groups although some local issue projects may need to be addressed by sub groups.
  I hope this is agreeable to all and thank you for your forbearance in allowing us extra time."
- Treasurers report: £1800 is in the account and Julian will be requesting contributions at the next meeting with the possible suggestion of £700 per LDC.
- Toby raised the interest of linking our websites. Emmanuel is looking to overhaul the West Sussex one. As a means to co-operation and cost sharing he will discuss potential developments with John Noakes (jnoakes@jpnitsolutions.co.uk (01634 828190)) who was the creator of the Kent and Surrey Website.

Date of the next meetings

24th April 2017 at 6pm Reigate manor hotel, Reigate